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Just Another Low-Risk Training Flight

U.S. ARMY COMBAT READINESS CENTER

"A specific area of concern is single-ship operations, which are most often categorized as low-risk operations. Multi-ship operations, the standard in combat, lower risk by adding experience, maturity, judgment and command attention to the mission. The more aviators involved in the planning and execution of a mission, the better the preparation and decision making. When briefing single-ship operations, specific involvement by the command and mission brief authority are required to identify all hazards and have thorough, honest dialogue with crews to (1) assess the aircrews' ability to conduct the mission and (2) ensure the appropriate level of pre-mission planning has taken place."
—GEN Richard A. Cody's thoughts on aviation risk management and leadership

What started out as a low-risk, single-ship training mission in the desert ended with two deceased crewmembers, four injured service members and a destroyed MEDEVAC aircraft. The accident crew was one of two MEDEVAC crews assigned to a remote forward operating base. They were the first-up crew and were going to conduct two hours of aircrew training manual training. The crew mix looked good on paper; both pilots were pilots-in-command, one with 920 hours and the other 690 hours. The crew chief and flight medic were experienced in the aircraft and the mission.

The mission was approved by the company commander (a major) and the Marine Corps' higher headquarters for day, night and night vision goggles and was rated low risk on the risk assessment worksheet. The crew would remain within 10 nautical miles of the FOB while conducting the training. They planned to fly unaided up to a lake north of the FOB for confined area operations, followed by pinnacle operations near another lake to the south. They then would return to the FOB, drop off the passengers, get fuel and continue with an hour of NVG training.

The UH-60A departed two minutes after official sunset. The flight proceeded as planned until they arrived at the pinnacle area next to the lake south of the FOB. Approximately 45 minutes into the flight during a visual meteorological conditions takeoff from the pinnacle, the aircraft impacted the water in a tail-low attitude. The Black Hawk flipped tail over nose, causing the main rotor blades to disintegrate and ripping the nose off the aircraft. It came to rest inverted in about 10 to 12 feet of water. Fortunately, the PC, pilot and two passengers emerged from the zero-visibility muddy water. Only one of these passengers, a former Navy flight surgeon, had previous dunker training. The crew chief and flight medic didn't survive.

Why?

Why did this accident happen? What could the crew have done better to prevent this accident?

- **Pre-mission and in-flight planning.** Flying over the desert unaided in an area of low contrast 49 minutes after official sunset doesn't pass the common sense test. The crew should've had their NVGs easily accessible since they were first-up MEDEVAC and could've launched on a mission anytime during the training flight. However, their NVGs were stowed in the back of the aircraft.

•**Flotation equipment.** The crew was in full compliance with Army Regulation 95-1 glide distance requirements for the over-water portion of the flight. The unit didn't deploy with flotation devices based on a METT-T analysis of the operations area. In theater, there are large bodies of water that might pose an over-water hazard based on flight altitudes. This company received only a partial fielding of the Air Warrior system at home station. Flotation components weren't issued to the unit, and the unit didn't bring the flotation equipment they had to theater. Commanders need to think through all possible mission profiles and ensure Soldiers are equipped to mitigate those risks.

•**Underwater egress and water survival.** Would dunker training have enabled the crew chief, who made it out of his seat, to reach the surface? The crew chief's body was recovered away from the main cabin near the nose wreckage. His body was free from all restraints, indicating he'd been physically able to exit the aircraft but drowned while attempting to surface.

Five of the six crewmembers hadn't been trained in underwater aircraft egress. As a result, the crewmembers had problems egressing because of disorientation, water pressure and zero visibility. The one crewmember who'd previously conducted water egress and survival training had no trouble exiting the aircraft. This is an Army-wide problem that's being addressed in Initial Entry Rotary Wing training but still requires a solution for the rest of Army Aviation.

•**Crew coordination.** Effective communication and interaction between the crewmembers was another missing tool. Had the pilot not on the controls properly performed his duties as outlined in the ATM, this accident wouldn't have happened. Every crewmember in that aircraft had a vital role to fulfill. It doesn't matter if the mission is in combat or training; a flight crew must always have their game face on. If this had been a combat mission instead of a "low-risk" training flight, the crew most likely would've put the proper emphasis on pre-mission planning and the appropriate level of vigilance required for flying in the desert during reduced light levels.

Editor's note: To read GEN Richard A. Cody's full message concerning leader involvement and mission planning in his June 23, 2006, "Thoughts on Aviation Risk Management and Leadership," go to the USACRC Web site at https://crc.army.mil/Guidance/detail.asp?iData=246&iCat=578&iChannel=15&nChannel=Guidance.

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Unfortunately, two Soldiers were killed during this low-risk mission. Preventable? Yes. How can leaders make a difference? When you're leading on the edge, think about the following:

•Leaders stay engaged
•Leaders are accountable
•Someone always knows
•Never leave a fallen comrade (and not just in the physical sense)